The January 1, 2002 Diagnosis Guidelines Can Affect Your Operations and Reimbursement

The Centers for Medicare and Medicaid Services (CMS), *Transmittal AB-01-144 (Change Request 1724)* dated September 26, 2001 and effective January 1, 2002 provides clarification regarding the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis coding guidelines for reporting diagnostic tests for outpatient facilities and physician offices.

Currently, about one-half of all Medicare carriers in the country require the coding submission of the patient's signs and symptoms, while the other half follow the *Official ICD-9-CM Coding Guidelines for Physician and Outpatient Services*, published by the American Hospital Association (AHA), which require the coding of the test results.

Is your practice operating in a state that required signs and symptoms? If so, you must be prepared to begin coding from the definitive diagnosis on January 1, 2002. Coding from signs and symptoms is generally easier and faster than coding from definitive diagnoses and your coders' production may decrease slightly with these new guidelines. Many coders, who usually code from signs and symptoms, may not be familiar with all of the diagnosis coding guidelines and can benefit from additional training to ensure correct code assignment.

Payment determination is most often driven by the diagnosis code assigned that indicates the medical necessity of the ordered exam. Medicare carriers develop Local Medical Review Policies that define the diagnoses and conditions which they deem as medical necessities and which ICD-9 codes result in payment. (A complete listing of policies can be found on the Local Medical Review Policies Web site). When assigning diagnosis codes for the outpatient facility and physician services, it is important to remember that documentation must be present in the radiology/nuclear medicine report for all coded conditions. The majority of radiology/nuclear medicine audits reveal greater diagnosis coding errors than procedure coding problems. Rule-out, probable, suspected, questionable, working, and consistent with conditions should not be coded as actual conditions.

Once a diagnosis code has been submitted for payment, the payor views the information as a clinical diagnosis from the physician and that information will remain on the patient's record for life. No matter what role the physician has in the coding process, he/she is responsible for the accuracy of the information submitted on the claim form.

<u>CMS Transmittal AB-01-144 Provides ICD-9-CM Diagnosis Coding Guidance:</u>

A. Determining the appropriate primary ICD-9-CM diagnosis code for diagnostic tests ordered due to signs and/or symptoms. If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs

and/or symptoms that prompted ordering the test may be reported as additional diagnoses, if they are not fully explained or related to the confirmed diagnosis.

Example: A patient is referred to a radiologist/nuclear medicine physician for an abdominal abscess scan with a diagnosis of abdominal pain. The nuclear medicine scan reveals the presence of an abscess. The nuclear medicine physician should report a diagnosis of "*intra-abdominal abscess*."

Example: A patient is referred to a radiologist/nuclear medicine for spine x-ray and/or bone scan due to complaints of "back pain." The radiologist/nuclear medicine physician performs the x-ray and/or scan, and the results are normal. The radiologist/nuclear medicine physician should report a diagnosis of "back pain" since this was the reason for performing the spine x-ray and/or bone scan. If the results of the diagnostic test are normal or non-diagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probably, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather, the interpreting physician should report the sign(s) or symptom(s) that prompted the study.

Note: Diagnoses labeled as uncertain are considered by the ICD-9-CM Coding Guidelines as unconfirmed and should not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

B. <u>Determination Instructions - Reason for the Test</u>

The Balanced Budget Act (BBA) §4317(b) specifies that referring physicians be required to provide diagnostic information to the testing entity at the time the test is ordered.

42 CFR 410.32 specifies that all diagnostic tests "must be ordered by the physician who is treating the beneficiary." As defined in §15021 of the Medicare Carrier Manual (MCM), an "order" is a communication from the treating physician requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

A written document signed by the treating physician, which is hand-delivered, mailed, or faxed to the testing facility.

A telephone call by the treating physician or his/her office to the testing facility.

An electronic mail by the treating physician or his/her office to the testing facility.

Note: If the order is communicated via telephone, both the treating physician or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records. On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record if it is available. However, every attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

C. Incidental findings should never be listed as primary diagnosis. If reported, incidental findings may be reported as secondary diagnoses by the physician interpreting the diagnostic test.

D. Unrelated and co-existing conditions/diagnoses may be reported as additional diagnoses by the physician interpreting the diagnostic test.

E. Diagnostic tests ordered in the absence of signs and/or symptoms (e.g. screening tests. When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the physician interpreting the diagnostic test should report the reason for the test (e.g. screening) as the primary ICD-9-CM diagnosis code. The results of the test, if reported, may be recorded as additional diagnoses.

F. Use of ICD-9-CM to the greatest degree of accuracy and completeness

Note: This section explains certain coding guidelines that address diagnoses coding. These guidelines are longstanding coding guidelines that have been part of the Official ICD-9-CM Guidelines for Coding and Reporting.

The interpreting physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from the test, or for the sign(s)/symptom(s) that prompted the ordering of the test.

In terms of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis.

Summary of the CMS memorandum - effective January 1, 2002:

All diagnostic tests should be coded with definitive findings (if applicable) and then signs and/or symptoms (if necessary).

Information can be obtained from the patient, if the referring physician is unavailable (but any information must be verified).

Incidental findings should only be coded as secondary diagnoses and never primary. Unrelated and co-existing conditions may be reported as additional diagnoses.

A screening exam is always a screening exam and all findings should be reported as secondary diagnoses.

The Official ICD-9-CM Guidelines for Coding and Reporting should be followed. If the new guidelines represent a change to your coding practices and operations, you need to get prepared immediately. Ensure your coders are adequately trained and ready to accurately assign definitive codes. Contact your local payor and ensure its local medical review policies have been updated to reflect appropriate definitive diagnoses, otherwise you may find numerous rejections and denials from your local carrier until its systems are updated appropriately.

Coding definitive diagnoses for outpatient and physician services has been the longstanding guideline published by the AHA. The majority of non-Medicare payors already follow these guidelines. If you have any questions regarding what your private payors require, obtain written guidance from each organization to ensure compliance with their guidelines.

Refer to the following web sites for additional information and updates:

Centers for Medicare and Medicaid Services (CMS), *Transmittal AB-01-144 (Change Request 1724)* released on September 26, 2001 and effective January 1, 2002.

http://www.hcfa.gov/pubforms/transmit/ab01144.pdf

National Center for Health Statistics.

http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guide.